Name_____ Date_____

Automobile Accident Questionnaire

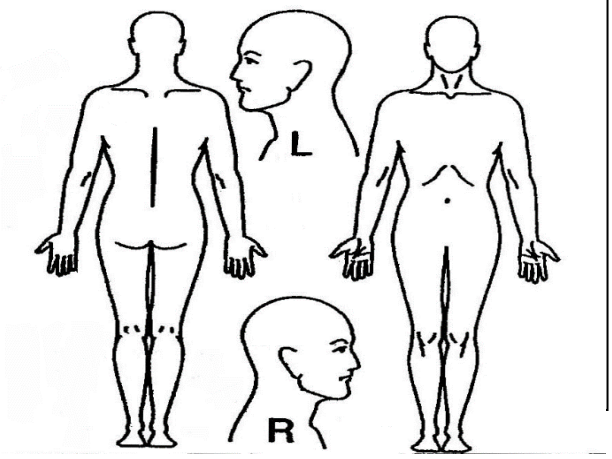
Nature of Accident

1. What was the time and date of this present injury? _____
2. Please explain in detail how your accident happened:_____

   _____
3. Type of vehicle_____
4. Other vehicle or object_____
5. Were you: Driver_____ Passenger _____Front seat _____ Back Seat_____
6. What was the speed of your vehicle?_____
7. Were you wearing a seat belt? Yes No Did an air bag deploy? Yes No
8. Did your head hit the head rest? Yes No
9. Where were you looking at the time of impact?_____
10. Did you come in contact with any objects in the car?_____ If yes, what objects? (i.e. windshield, steering frame)?_____
11. What parts of your body came in contact with the above object(s) _____
12. Were you unconscious as a result of the injury? _____If yes, how long?_____

Show area(s) of pain or unusual feeling immediately after accident. Mark the areas on this body where you felt the describing sensations. Use appropriate symbols in all affected areas

Numbness	Pins & Needles	Burning	Aching	Stabbing
xxxxxx	•••••••	ooooo	vvvvv	IIIIIIII
xxxxxx	•••••••	ooooo	vvvvv	IIIIIIII
xxxxxx	•••••••	ooooo	vvvvv	IIIIIIII



13. What part of the vehicle is damaged?_____

    _____
14. How were you moving (forward, turning backing)?
15. What was your speed?_____
16. How was the other vehicle moving? (forward, turning, backing)?
17. What was the speed of the other vehicle?_____
18. Was the other vehicle damaged? _____
19. Were the police notified? Yes No
20. Was a report taken?_____
21. Was the car towed? Yes No
22. Was EMS at the scene? Yes No

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23. Where did you go after the accident? How?_____

24. What treatment have you had since the accident?_____

25. Are you having any symptoms as a result of the accident?_____

Was any other doctor consulted after your accident?_____ If yes, what is the doctor's Name?_____

_____ DC _____MD _____DO _____DDS

26. Describe the doctor's diagnosis_____

27. What treatment did you receive?_____

28. Are you still under a doctor's care?_____ If yes, please explain_____

Past History

1. Have you ever injured this area before? _____ If yes, when?_____
2. Have you been involved in any previous accidents of any kind? (Personal injury, automobile accident, or workers' compensation) _____ If yes, please explain dates and details _____

   _____
3. Have you enjoyed good health prior to this accident? _____ If no, please explain (i.e., illness, or injuries)_____

Present Information / Disability

1. Have you returned to work? _____ If yes, date returned_____
2. Job description_____
3. Are your work activities restricted as a result of this accident? _____ If yes, please explain_____

   _____
4. Do you notice any activity restrictions as a result of this accident? _____ If yes, Please explain_____

   _____
5. Since this injury are your symptoms: Improving _____ , getting worse _____ , or the same _____

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Legal Representation

1. Have you retained an attorney? _____ If yes, name and address_____

   _____

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____

Patient's Signature Date

_____ _____

Doctor's Signature (upon review) Date

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